

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**CENTERSTONE OF FLORIDA**

**2020 26TH AVENUE EAST  
BRADENTON, FL 34208**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced complaint investigation, CCR# 2017004801, was conducted at Centerstone of Florida, a crisis stabilization unit, on License #1467.</p> <p>Centerstone of Florida had deficiencies at the time of the investigation.</p>	C 000		
C 103	<p>65E-12.107(2)(e) FAC Minimum - C S U Admission - Lab Work</p> <p>(2) Admission. (e) Laboratory Work. Laboratory work and other diagnostic procedures deemed necessary shall be performed as ordered by the physician or psychiatrist.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review, policy review, document review and staff interview it was determined the facility failed to ensure laboratory work was performed as ordered by the physician for one (#3) of three sampled clients.</p> <p>Findings included:</p> <p>The record for Client #3 included documentation indicating the client was admitted to the facility on at 11:07 a.m.</p> <p>The Physician Orders dated at 11:37 a.m. and signed by the attending psychiatrist included orders to obtain specimens to perform diagnostic laboratory testing for a ... with Differential, a Comprehensive Panel and ... levels. The record included documentation the necessary ... samples were not obtained until at 8:30 a.m., over 2</p>	C 103		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 103	<p>Continued From page 1</p> <p><b>1/2 days following the physician order.</b></p> <p>The review of the facility policy titled "Admission Physicals, Lab, _____ Tests, _____ Studies, _____ Drug Screens", Practice #610, dated _____ included documentation indicating admitting laboratory work was to be obtained as ordered for patients entering the facility.</p> <p>Review of the document titled "Lab Workflow" revealed all routine laboratory work ordered during the day will be drawn the next morning unless otherwise indicated by the physician.</p> <p><b>The facility was unable to provide evidence all members of the currently credentialed medical staff had been informed of the facility's practice to delay obtaining routine laboratory specimens that were ordered on Fridays, Saturdays and the day before holidays, until the next business day.</b></p> <p>An interview and record review were conducted with the <b>Laboratory Services Manager</b> on _____ at 2:30 p.m. The Manager indicated "all the doctors know" the facility will not draw routine samples until the next business day. She stated the record indicated the orders for routine laboratory tests for Client #3 were written on a Friday. The sample was collected the next business day, a Monday, as was the usual practice at the facility. The Manager indicated the reason for <b>delaying the collection of routine samples on weekends and holidays was the facility did not have and does not arrange for the availability of qualified staff</b> required to obtain _____ samples on weekends and holidays.</p> <p>The Manager confirmed the finding the physician ordered routine laboratory tests for Client #3 and the tests were not performed as ordered in</p>	C 103			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 103	Continued From page 2  compliance with facility policy.	C 103			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**CENTERSTONE OF FLORIDA**

**2020 26TH AVENUE EAST  
BRADENTON, FL 34208**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB000	Initial Comments  <b>An unannounced complaint investigation, CCR# 2017004801, was conducted at Centerstone of Florida, a crisis stabilization unit, on License #1467.</b>  <b>Centerstone of Florida had deficiencies at the time of the investigation.</b>	BB000		
BB043	65E-5.170(1)(d)-(7) FAC Express & Informed Consent  <b>Right to Express and Informed Consent</b> (1) Establishment of Consent. (d) <b>In the event there is a change in the ability of a person on voluntary status to provide express and informed consent to treatment, the change shall be immediately documented in the person's clinical record. A person's refusal to consent to treatment is not, in itself, an indication of incompetence to consent to treatment.</b> 1. If the person is assessed to be competent to consent to treatment and meets the criteria for involuntary inpatient placement, the facility administrator shall file with the court a petition for involuntary inpatient placement. Recommended form CF-MH 3032, _____ 05, "Petition for Involuntary Inpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. 2. If the person is assessed to be _____ to consent to treatment, and meets the criteria for involuntary inpatient or involuntary outpatient placement, the facility administrator shall expeditiously file with the court both a petition for the adjudication of incompetence to consent to treatment and appointment of a guardian advocate, and a petition for involuntary inpatient or involuntary outpatient placement. Upon	BB043		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
BB043	<p>Continued From page 1</p> <p>determination that a person is ... to consent to treatment the facility shall expeditiously pursue the appointment of a duly authorized substitute decision-maker that can make legally required decisions concerning treatment options or refusal of treatments for the person. Recommended forms CF-MH 3106, ... 05, "Petition for Adjudication of Incompetence to Consent to Treatment and Appointment of a Guardian Advocate," which is incorporated by reference may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter, and CF-MH 3032, "Petition for Involuntary Inpatient Placement," as referenced in subparagraph 65E-5.170(1)(d)1., F.A.C., or CF-MH 3130, "Petition for Involuntary Outpatient Placement," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose.</p> <p>(e) Competence to provide express and informed consent shall be established and documented in the person's clinical record prior to the approval of a person's transfer from involuntary to voluntary status or prior to permitting a person to consent to his or her own treatment if that person had been previously determined to be ... to consent to treatment. Recommended form CF-MH 3104, "Certification of Person's Competence to Provide Express and Informed Consent," as referenced in paragraph 65E-5.170(1)(c), F.A.C., properly completed by a physician may be used for this purpose.</p> <p>(f) Any guardian advocate appointed by a court to provide express and informed consent to treatment for the person shall be discharged and a notice of such guardian advocate discharge provided to the court upon the establishment and</p>	BB043			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
BB043	<p>Continued From page 2</p> <p>documentation that the person is competent to provide express and informed consent.</p> <p>(g) If a person entering a designated receiving or treatment facility has been _____ under Chapter 744, F.S., as described in Section 394.455(14), F.S., express and informed consent to treatment shall be sought from the person's guardian.</p> <p>(h) If a person entering a designated receiving or treatment facility has been determined by the attending physician to be _____ to consent to treatment as defined in Section 394.455(15), F.S., express and informed consent to treatment shall be expeditiously sought by the facility from the person's guardian advocate or health care surrogate or proxy.</p> <p>(i) A copy of the letter of guardianship, court order, or advance directive shall be reviewed by facility staff to ensure that the substitute decision-maker has the authority to provide consent to the recommended treatment on behalf of the person. If the facility relies upon the expression of express and informed consent for person's treatment from a substitute decision-maker, a copy of this documentation shall be placed in the person's clinical record and shall serve as documentation of the substitute decision-maker's authority to give such consent. With respect to a health care proxy, where no advance directive has been prepared by the person, facility staff shall document in the person's clinical record that the substituted decision-maker was selected in accordance with the list of persons and using the priority set out in Section 765.401, F.S. When a health care surrogate or proxy is used, the facility shall</p>	BB043			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
BB043	<p>Continued From page 3</p> <p>immediately file a petition for the appointment of a guardian advocate.</p> <p>(2) Authorization for Treatment.</p> <p>(a) Express and informed consent, including the right to ask questions about the proposed treatment, to receive complete and accurate answers to those questions, and to negotiate treatment options, shall be obtained from a person who is competent to consent to treatment. If the person is ..... to consent to treatment, such express and informed consent shall be obtained from the duly authorized substitute decision-maker for the person before any treatment is rendered, except where emergency treatment is ordered by a physician for the safety of the person or others. Chapter 394, Part I, F.S., and this rule chapter govern mental health treatment. Medical treatment for persons served in receiving and treatment facilities and by other service providers are governed by other statutes and rules.</p> <p>(b) A copy of information disclosed while attempting to obtain express and informed consent shall be given to the person and to any substitute decision-maker authorized to act on behalf of the person.</p> <p>(c) When presented with an event or an alternative which requires express and informed consent, a competent person or, if the person is ..... to consent to treatment, the duly authorized substitute decision-maker shall provide consent to treatment, refuse consent to treatment, negotiate treatment alternatives, or revoke consent to treatment. Recommended forms CF-MH 3042a, . 05, "General Authorization for Treatment Except ..... Medications," which is incorporated by reference and may be obtained pursuant to Rule</p>	BB043			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB043	Continued From page 4  65E-5.120, F.A.C., of this rule chapter, and CF-MH 3042b, . . . 05, "Specific Authorization for . . . Medications," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used as documentation of express and informed consent and any decisions made pursuant to that consent. If used, recommended form CF-MH 3042a, "General Authorization for Treatment Except . . . Medications," as referenced in paragraph 65E-5.170(2)(c), F.A.C., shall be completed at the time of admission to permit routine medical care, . . . assessment, and other assessment and treatment except . . . medications. The more specific recommended form CF-MH 3042b, "Specific Authorization for . . . Medications," as referenced in paragraph 65E-5.170(2)(c), F.A.C., or its equivalent, shall be completed prior to the administration of any . . . medications, except under an emergency treatment order. The completed forms, or equivalent documentation, shall be retained in the person's clinical record. (d) No facility or service provider shall initiate any mental health treatment, including . . . medication, until express and informed consent for . . . treatment is sought from a person legally qualified to give it, except in instances where emergency treatment is ordered by a physician to preserve the immediate safety of the person or others. (3) Receiving and treatment facilities shall request copies of any advance directives completed by persons admitted to the facilities, from the person or the person's family or representative. (4) In addition to any other requirements, at least the following must be given to the person before	BB043		



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
BB043	<p>Continued From page 5</p> <p>express and informed consent will be valid:</p> <p>(a) Identification of the proposed , , , , , medication, together with a plain language explanation of the proposed dosage range, the frequency and method of administration, the recognized short-term and long-term side effects, any contraindications which may exist, clinically significant interactive effects with other medications, and similar information on alternative medications which may have less severe or serious side effects.</p> <p>(b) A plain language explanation of all other treatments or treatment alternatives recommended for the person.</p> <p>(5) If a change in , , , , , medication is recommended which is not included in the previously signed CF-MH 3042b, "Specific Authorization for , , , Medications" form, as referenced in paragraph 65E-5.170(2)(c), F.A.C., after an explanation and disclosure of the altered treatment plan is provided by the physician express and informed consent must be obtained from the person authorized to provide consent and be documented in the person's clinical record prior to the administration of the treatment or , , , , , medication.</p> <p>(6) The facility or service provider staff shall explain to a guardian, guardian advocate, or health care surrogate or proxy, the duty of the substitute decision-maker to provide information to the facility or service provider on how the substitute decision-maker may be reached at any time during the person's hospitalization or treatment to provide express and informed consent for changes of treatment from that previously approved.</p> <p>(7) Electroconvulsive treatment may be recommended to the person or the person's substitute decision-maker by the attending</p>	BB043			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
BB043	Continued From page 6  physician. Such recommendation must also be concurrently recommended by at least one other physician not directly involved with the person's care who has reviewed the person's clinical record. Such recommendation shall be documented in the person's clinical record and shall be signed by both physicians. Recommended form CF-MH 3057, . 05, "Authorization for Electroconvulsive Treatment," which is incorporated by reference and may be obtained pursuant to Rule 65E-5.120, F.A.C., of this rule chapter may be used for this purpose. If used, this form shall also be signed by the person, if competent, or by the guardian advocate, if previous court approval has been given, or by the guardian where the person has been found by the court to be incompetent, or by the health care surrogate if the person had expressly delegated such authority to the surrogate in the advance directive. Express and informed consent from the person or his or her substitute decision-maker, as required by Section 394.459(3), F.S., including an opportunity to ask questions and receive answers about the procedure, shall be noted on or attached to recommended form CF-MH 3057, "Authorization for Electroconvulsive Treatment," as referenced in subsection 65E-5.170(7), F.A.C., or its equivalent, as documentation of the required disclosures and of the consent. Each signed authorization form is permission for the person to receive a series of up to, but not more than, the stated number of electroconvulsive treatments identified on the form. Additional electroconvulsive treatments require additional written authorization. The signed authorization form shall be retained in the person's clinical record and shall comply with the provisions of Section 458.325, F.S.	BB043			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB043	<p>Continued From page 7</p> <p>This Statute or Rule is not met as evidenced by: Based on record review, policy review and staff interview it was determined the facility failed to ensure the guardian parent of a minor provided informed consent to the administration of a medication for one (#3) of three sampled clients.</p> <p>Findings included:</p> <p>The record for Client #3 included documentation the client was a minor child. The name and contact information of the client's parental guardian was included in the record.</p> <p>The Physician Orders dated at 11:43 a.m. and signed by the attending psychiatrist included an order to administer 10 milligrams (mg) to Client #3 each night at bedtime. The review of the Medication Administration Record included documentation signed by the Registered Nurse (RN) indicating the ordered dose of was administered on at 8:32 p.m.</p> <p>The "Request for Consent for Medication Treatment" included a list of common medications in the category. The list included the medication. The review of the record for Client #3 revealed the "Consent for Medication Treatment" was signed by parent guardian on indicating the informed consent for the administration of the medication was obtained two days after the medication was first administered. The detailed review of the record failed to reveal any evidence informed consent was obtained prior to the administration of on</p> <p>The facility policy "Client Medication and</p>	BB043		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>CS17910012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/05/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CENTERSTONE OF FLORIDA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2020 26TH AVENUE EAST BRADENTON, FL 34208</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
BB043	<p>Continued From page 8</p> <p>Education and Consent for Medication Treatment", policy number IIA13.%CFL, dated _____, was reviewed on _____. The policy indicated clients are to be fully informed of the potential benefits and risks of taking _____ medications and must provide their written consent for medication treatment at the time such treatment is provided.</p> <p>The facility policy "Client Rights and Responsibilities", policy number IIA13.2.CFL, dated _____, was reviewed on _____. The policy indicated the rights and personal liberties of all clients will be upheld by all staff. The list of patient rights included documentation indicating the right to be given information regarding the planned course of treatment, alternatives and risks. The client also has the right to refuse any treatment.</p> <p>An interview and record review was conducted with the Risk Manager on _____ at 2:00 p.m. She confirmed the finding informed consent to administer a _____ medication was not provided to the legal guardian of Client #3 on or before the time of the medication administration on _____. In addition, the legal guardian was not provided an opportunity to consent to or refuse the treatment prior to the medication being given.</p>	BB043			